

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection 103 South Main Street, Ladd Hall Waterbury, VT 05671-2306 http://www.dail.vermont.gov Voice/TTY (802) 871-3317 To Report Adult Abuse: (800) 564-1612

Fax (802) 871-3318

February 3, 2012

Mr. James Beeler, Administrator Rowan Court Health & Rehab 378 Prospect Street Barre, VT 05641-5421

Provider #: 475037

Dear Mr. Beeler:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **January 5**, **2012**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN, MS

Licensing Chief

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PRINTED: 01/19/2012 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		475037	B. WIN				C 5/2012
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F 000	INITIAL COMMEN	тѕ	F	000			
F 281 SS=J	was conducted from Division of Licensing of the investigation identified which also of Substandard Quas follows. 483.20(k)(3)(i) SEP PROFESSIONAL SEPROFESSIONAL SEPROFESS	ded or arranged by the facility ional standards of quality. NT is not met as evidenced wand record review, the facility at one applicable resident hat meet professional y in regards to accurate and appropriate medication sident #1). Findings include: ation from January 4 - January views and record review	F:	281	Resident # 1 Admitter Care, expired on 1/1, from natural causes, end stage liver cance documented on the of Systems in place at the isolated incident were properly. Policies and in place. Verification orders was made by time the orders were The Ambien order was available in the median	with diagnosis or/hepatitis C adeath certificate the time of this re operating d Procedures was of the APRN 2 nurses at the ereceived. as current and ication cart. In additional coringing the top	s of s te. vere
	errors occurred, at Resident #1 was g valid order, withou Resident's respont the absence of ind staff notes, Reside 12/27/11 for end o as alert, oriented, known. From 12/2 12/31/11, the resident bulating with a	ries of significant medication fecting Resident #1, in which iven medications without a tradequate monitoring of the se to the medications and in ications for use. Per review of ent #1 was admitted on f life care due to Liver Cancer and able to make his/her needs 8/11 through the evening of lent was noted to be walker independently and was	·		a three check peer re Nurse #1 has an audi pass weekly. Nurses monitoring plan in pl all orders are review DNS/designee.	it of a medicati #2 and #4 hav lace to ensure	e a

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 01/05/2012	
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F 281	on December 31 recipient of a sign the resident rece Ambien (a sedati insomnia) when the administer 2 mg medication). The significant medical record in assessments during the process of the polymer of the polymer of the medication of the	when s/he needed medications			All residents receiving medications hav the potential to be affected by this alleged deficit practice. Nurses were re-educated on medication administration policy. Nurses were re-educated on the policy and procedure for clinical documentation for medication errors to include not only the incident report but in addition, a notation in the medical		ion Cy i to out
	telephone orders Nurse #1 on 12/ countersigned b mg Ativan every cream 1 mg top 4 mg Morphine s throughout the n cream that conta (anti-anxiety), Bo (anti-psychotic) nausea). Prior to dosages of the i follows for an 'a agitation, orders	w on 1/4/12, the following were transcribed and signed by 31/11 at 10:30 PM and were not by the prescribing practitioner: 2 4 hours while awake, ABHR cal every 2 hours scheduled, and subcutaneously every 2 hours light. ABHR cream is a topical ains 4 medications: Ativan enadryl (anti-histamine), Haldol and Reglan (used for treatment of this telephone order, the included medications were as a needed' dose to treat anxiety or ed on 12/29/11: 0.5 mg of Ativan, adryl, 0.5 mg of Haldol, and 10 mg			Nurses were re-educated for editing and transcribin orders.		

Event ID: 651N11

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AND DI AN OF CORRECTION IDENTIFICATION NUMBER	1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 281	effects for 3 of 4 include drowsine Per interviews or 4:20 PM with the on the telephone stated that s/he of Nurse #1, but gawho was not in the verified that s/he given every 4 ho ordered a one tir increased anxiet prior to the significant Ambien. The NF order the ABHR scheduled, and a Morphine was to	eview of drug information, side of the included medications	F 281	The nurses responsible medication errors wer re-educated on the me administration process errors policy. Daily review of new or performed by DNS/de check by nurses x 90 downweekly audits x 90 day passes.	e disciplined and edication s and medication of the same of the signee for triple lays.
	and the Morphin medications to to the anxiety/agitation. Throughout the and through the and ABHR creations (Nurse # per the above mon 12/31/11. Per Resident #1 slettle 1/1/12, and a not states the resident that the nurse coream and 4 mg	chone order, the ABHR creame were PRN (as needed) reat complaints of and pain, respectively. In the shift of 12/31/11 - 1/1/12 day shift on 1/1/12, the Morphine of were given by 2 different and Nurse #4) every 2 hours the entioned telephone orders written for review of nurses' notes, but all night from 12/31/11 to be for the day shift of 1/1/12 ent slept throughout the shift, and continued to administer the ABHR of Morphine every 2 hours as urses' note by Nurse #3 on 1/1/12		DNS/designee will prooversight to the nurse involved in the medicadays. Results of these audit at monthly CQI meeting Date of compliance: J	s that were ation errors for 90 s will be reviewed ng x 3 months.

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		475037	B. WING	G	1	C 05/2012
	PROVIDER OR SUPPLIER COURT HEALTH &			STREET ADDRESS, CITY, STATE, ZIP 378 PROSPECT STREET BARRE, VT 05641	CODE	
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F 281	also states that the of apnea (temporal early at 9:30 AM, Morphine and AB signs or complaint confirmed by Nursinterview on 1/5/1 was not exhibiting of pain or anxiety the nurse stated to repeatedly given symptoms. The 7 doses of A absence of signs anxiety/agitation of 1/1/12 were giver were based on in of Morphine giver complaints of paint 1/1/12 were giver without a physicial scheduled dose. The medical recomplaints of paint 1/1/12. There nurses (Nurse #3 prescribing practing question the schedules of ABH asleep and/or haresident passed in the schedules of th	e resident was having periods ary cessation of breathing) as yet staff continued to give the HR cream in the absence of its of pain or anxiety. It was se #3 during a telephone 2 at 1:10 PM, that Resident #1 yeigns of, nor made complaints during the day on 1/1/12, and hat the Morphine was to treat the resident's respiratory. BHR cream given in the or complaints of from 2:00 AM to 2:00 PM on a without indications for use and walid orders. Also, the 3 doses in in the absence of signs or in from 9:30 AM to 1:30 PM on a without indications for use and an's order to continue with the There was no order present in the document of the daytime hours is no evidence of either of the 2 for Nurse #4) contacting the itioner or physician on-call to eduled administration of the IR cream when the resident was ving periods of apnea. The away around 3:30 PM on 1/1/12.	F 2	81		
·	information, the reformation patients with prolonged elimin	drug manufacturer's prescribing recommended dose of Ambien iver impairment is 5 mg due to ation (the body taking longer to sliminate the drug). Precautions				

	FOF DEFICIENCIES OF CORRECTION	(X1)· PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	ULTIPLE (LDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		475037	B. WI	IG		l l	C 5/2012
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F 281	liver impairment to closely. Drug inte statement that it heffects with combined in the effects with combined in the liver, and is incomposed in the liver, and	Ambien include for patients with a use with caution and monitor ractions for Ambien include a as enhanced CNS depressant nation use. ication information, Morphine depression, is metabolized by dicated to be used for from severe pain. listed include respiratory facturer's warnings include a ution and use Morphine in a patients who are concurrently datives/hypnotics or central CNS) depressants. Precautions phine include a statement that we a prolonged duration and in patients with liver g that in patients with	F	281			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MUL A. BUILD	TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
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F 281	Wolters Kluwer He Wilkins, pgs 14 & Pharmaceutical Information Retreive http://www.rxmed.com/	of Nursing Practice (9th ed.). ealth/Lippincott Williams & 17. formation: Morphine Sulfate ed January 5, 2012, from com. cribing Information: Ambien.	F 28			
	Pharmaceutical In January 5, 2012, for Pharmaceutical In January 5, 2012, for	formation: Haldol. Retreived rom http://www.rxmed.com. formation: Benadryl. Retreived rom http://www.rxmed.com. formation: Ativan. Retrieved		F 329		
F 329 SS=J	January 5, 2012, f 483.25(I) DRUG R UNNECESSARY I Each resident's dr unnecessary drug drug when used in duplicate therapy) without adequate indications for its to adverse conseque should be reduced combinations of the	rom http://rxmed.com. IEGIMEN IS FREE FROM DRUGS ug regimen must be free from s. An unnecessary drug is any n excessive dose (including g; or for excessive duration; or monitoring; or without adequate use; or in the presence of ences which indicate the dose d or discontinued; or any ne reasons above.	F 32	Resident # 1 Admitted to Care, expired on 1/1/12 from natural causes, wi end stage liver cancer/h documented on the dead Systems in place at the isolated incident were opposerly. Policies and P in place. Verification of orders was made by 2 n time the orders were re	2. Death was th diagnosis of nepatitis C as ath certificate. time of this operating Procedures were the APRN ourses at the	
	who have not use given these drugs	ty must ensure that residents d antipsychotic drugs are not unless antipsychotic drug ary to treat a specific condition		The Ambien order was of available in the medicat		

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F 329	as diagnosed and record; and resider drugs receive grad behavioral interver contraindicated, in drugs. This REQUIREME by: Based on interview failed to ensure that free from unneces Findings include: During the investig 5, 2012, staff interverealed that a ser errors occurred, at Resident #1 was givalid order, withou Resident's responsithe absence of ind staff notes, Reside 12/27/11 for end of alert, oriented, and known. From 12/2 12/31/11, the resident with a able to ask staff with treat symptoms. On December 31, recipient of a significant intervence.	documented in the clinical of the who use antipsychotic ual dose reductions, and ations, unless clinically an effort to discontinue these. NT is not met as evidenced of an are applicable resident was sary drugs (Resident #1). Aution from January 4 - January views and record review ries of significant medication fecting Resident #1, in which riven medications without a tradequate monitoring of the se to the medications and in ications for use. Per review of ent #1 was admitted on fife care from Liver Cancer as trade able to make his/her needs 8/11 through the evening of the walker independently and was hen s/he needed medications.	F	329	The facility did add one of physician orders, broathree check peer reviewed pass weekly. Nurses # monitoring plan in place all orders are reviewed DNS/designee. All residents receiving the potential to be affealleged deficit practice. Nurses were re-educated administration policy. Nurses were re-educated and procedure for clinical documentation for mediculation, a notation record. Nurses were re-educated for editing and transcriptions orders.	inging the toticew of a medication 2 and #4 have the totice to ensure the diby medications leected by this the don medication erro cident report in the medication the potential	al to on e a hat have ation licy rs to but al
	recipient of a signi						

NAME OF PROVIDER OR SUPPLIER ROWAN COURT HEALTH & REHAB SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG CAMPILL REGULATORY OR LSC IDENTIFYING INFORMATION F 329	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		DENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ROWAN COURT HEALTH & REHAB SUMMARY STATEMENT OF DEFICIENCIES BARRE, VT 05541 (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGS REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAGS PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 329	· · 2 						1	٠
F 329 Continued From page 7 Ambien (a sedative/hypnotic medication used for insomnia) when the nurse was intending to administer 2 mg of Ativan (an anti-anxiety medication). There is no evidence of this significant medication error in the Resident's medical record nor evidence of ongoing assessments during the following shifts in regards to the potential effects of the medication error. Per record review, Resident #1 had a previous PRN (as needed) order for Ambien 5 mg for insomnia that was discontinued on 12/29/11, but per staff interview with Nurse #1 on 1/4/12, the medication card was still in the medication cart on 12/31/11, available for staff to use. F 329 The nurses responsible for the medication errors were disciplined and re-educated on the medication administration process and medication errors policy. Daily review of new orders will be performed by DNS/designee for triple check by nurses x 90 days. DNS/designee will perform random weekly audits x 90 days of medication passes. Per record review on 1/4/12, the following telephone orders were transcribed and signed by			L		37	8 PROSPECT STREET	1 0170	5/2012
Ambien (a sedative/hypnotic medication used for insomnia) when the nurse was intending to administer 2 mg of Ativan (an anti-anxiety medication). There is no evidence of this significant medication error in the Resident's medical record nor evidence of ongoing assessments during the following shifts in regards to the potential effects of the medication error. Per record review, Resident #1 had a previous PRN (as needed) order for Ambien 5 mg for insomnia that was discontinued on 12/29/11, but per staff interview with Nurse #1 on 1/4/12, the medication card was still in the medication cart on 12/31/11, available for staff to use. Per record review on 1/4/12, the following telephone orders were transcribed and signed by The nurses responsible for the medication re-educated on the medication administration process and medication administration process and medication errors policy. Daily review of new orders will be performed by DNS/designee for triple check by nurses x 90 days. DNS/designee will perform random weekly audits x 90 days of medication passes. DNS/designee will provide enhanced	PRÉFIX	(FACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF	ıx	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	OULD BE	(X5) COMPLETION DATE
Nurse #1 on 12/31/11 at 10:30 PM and were not countersigned by the prescribing practitioner: 2 mg Ativan every 4 hours while awake, ABHR cream 1 mg topical every 2 hours scheduled, and 4 mg Morphine subcutaneously every 2 hours throughout the night. ABHR cream is a topical cream that contains 4 medications: Ativan (anti-anxiety), Benadryl (anti-histamine), Haldol (anti-psychotic) and Reglan (used for treatment of nausea). Prior to this telephone order, the dosages of the included medications were as follows for an 'as needed' dose to treat anxiety or agitation, ordered on 12/29/11: 0.5 mg of Ativan, 12.5 mg of Benadryl, 0.5 mg of Haldol, and 10 mg of Reglan. Per review of drug information, side effects for 3 of 4 of the included medications include drowsiness/sedation.	F 329	Ambien (a sedative insomnia) when the administer 2 mg of medication). There significant medical medical record nor assessments durin regards to the pote error. Per record revious PRN (as for insomnia that we but per staff intervious the medication carcart on 12/31/11, and the medication carcart on 12/31/11, and the medication carcart on 12/31/11, and the medication carcart on 12/31 countersigned by the medication of the medication. Prior to dosages of the incomposition of the medication, ordered 12.5 mg of Benadiof Reglan. Per receffects for 3 of 4 of the medication of the medication.	e/hypnotic medication used for enurse was intending to Ativan (an anti-anxiety e is no evidence of this ion error in the Resident's evidence of ongoing g the following shifts in ential effects of the medication eview, Resident #1 had a needed) order for Ambien 5 mg vas discontinued on 12/29/11, ew with Nurse #1 on 1/4/12, d was still in the medication eview transcribed and signed by /11 at 10:30 PM and were not he prescribing practitioner: 2 hours while awake, ABHR all every 2 hours scheduled, and boutaneously every 2 hours ht. ABHR cream is a topical as 4 medications: Ativan adryl (anti-histamine), Haldol and Reglan (used for treatment of this telephone order, the sheeded' dose to treat anxiety or on 12/29/11: 0.5 mg of Ativan, ryl, 0.5 mg of Haldol, and 10 mg view of drug information, side f the included medications		329	medication errors were of re-educated on the med administration process a errors policy. Daily review of new order performed by DNS/designed will perforweekly audits x 90 days of passes. DNS/designee will provide oversight to the nurses the involved in the medication days. Results of these audits we at monthly CQI meeting of compliance: January Date of complian	disciplined a ication and medication are will be gnee for tripings. If medication are	on d 90 ed

STATEMEN [®] AND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION ING	COMPLE	ETED
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F 329	stated that s/he of Nurse #1, but ga who was not in the verified that s/he given every 4 howordered a one time given for increases the NP prior to the involving Ambier did not order the hours scheduled scheduled Morph throughout the nurse scheduled Morph throughout the nurse (Nurse # per the above mon 12/31/11. Per Resident #1 sleen 1/1/12, and a nurse scheduled that the nurse coream and 4 moyordered. The nurse scheduled that the nurse coream and 4 moyordered. The nurse scheduled that the nurse coream and 4 moyordered. The nurse scheduled that the nurse coream and 4 moyordered. The nurse scheduled that the nurse coream and 4 moyordered. The nurse scheduled that the nurse coream and 4 moyordered. The nurse scheduled that the nurse coream and 4 moyordered. The nurse scheduled that the nurse coream and 4 moyordered. The nurse scheduled that the nurse coream and 4 moyordered. The nurse scheduled that the nurse coream and 4 moyordered. The nurse scheduled that the nurse core core and a moyordered scheduled that the nurse core core and a moyordered scheduled that the nurse core core and a moyordered scheduled that the nurse core core and 4 moyordered scheduled that the nurse core core and 4 moyordered scheduled that the nurse core core and 4 moyordered scheduled that the nurse core core and 4 moyordered scheduled that the nurse core core and 4 moyordered scheduled that the nurse core core and 4 moyordered scheduled that the nurse core core and 4 moyordered scheduled that the nurse core core and 4 moyordered scheduled that the nurse core core and 4 moyordered scheduled that the nurse core core and 4 moyordered scheduled that the nurse core core and 4 moyordered scheduled that the nurse core core and 4 moyordered scheduled that the nurse core core and 4 moyordered scheduled that the nurse core core and 4 moyordered scheduled that the nurse core core and 4 moyordered scheduled that the nurse core core and 4 moyordered scheduled that the nurse core core and 4 moyordered scheduled that the nurse core core core core core c	order as giving the orders, s/he did not give the above orders to ve different orders to Nurse #2 he facility at the time. The NP did not order Ativan 2 mg to be surs while awake, but rather he dose of Ativan 2 mg to be ed anxiety that was reported to he significant medication error he. The NP also verified that she ABHR cream to be given every 2, and also verified that the hine was to be given only	F 32	9		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		475037	B. WII			01/05	5/2012
	PROVIDER OR SUPPLIER COURT HEALTH & R	EHAB		37	EET ADDRESS, CITY, STATE, ZIP CODE 78 PROSPECT STREET ARRE, VT 05641		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 329	interview on 1/5/12 was not exhibiting of pain or anxiety of the nurse stated the repeatedly given to symptoms. The 7 doses of AB absence of signs of anxiety/agitation from 1/1/12 were given of were based on involving for Morphine given complaints of pain 1/1/12 were given without a physician scheduled dose. The medical record Morphine administion 1/1/12. There is nurses (Nurse #3 of prescribing practiting question the scheduled dose information, the refor patients with livering prolonged eliminate metabolize and eliminate and warnings for Aliver impairment to closely. Drug interviews	at 1:10 PM, that Resident #1 signs of, nor made complaints turing the day on 1/1/12, and at the Morphine was treat the resident's respiratory. HR cream given in the recomplaints of the resident's respiratory without indications for use and alid orders. Also, the 3 doses in the absence of signs or from 9:30 AM to 1:30 PM on without indications for use and it's order to continue with the There was no order present in to continue the scheduled ration into the daytime hours in no evidence of either of the 2 or Nurse #4) contacting the oner or physician on-call to duled administration of the continue the resident was no periods of apnea. The way around 3:30 PM on 1/1/12. Irug manufacturer's prescribing commended dose of Ambien er impairment is 5 mg due to ion (the body taking longer to minate the drug). Precautions include for patients with ouse with caution and monitor ractions for Ambien include a as enhanced CNS depressant	F	329			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION NUMBER: A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		475037	B. WIN			į.	C 5/2012
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F 329	Per review of drug respiratory depression, Ches set in states the are respiratory with other tranquother CNS depression, resparrest. Symptom depression, Ches occur. References: Pharmaceutical Injection. Retreithter of the respiratory depression. Retreithttp://www.rxmed.	g information, Morphine causes ssion, is metabolized by the ated to be used for symptomatic pain. Contra-indications listed y depression. Manufacturer's a warning to use caution and a reduced dosage in patients ently receiving other loss or central nervous system loss. Precautions for the use of a statement that Morphine may duration and cumulative effect loss of the effects of states of the effects of states of loss or even up to 24 hours and dose and that continuous ould be avoided. Listed drug that Morphine in combination litizers, sedative/hypnotics or ssants has additive depressant lost a dosage reduction of one or quired. The adverse reactions at the major hazards of morphine expression, circulatory irratory arrest, shock and cardiac is of overdose include respiratory loss of overdose respiration, extreme d in severe overdosage, apnea, se, cardiac arrest and death may enformation: Morphine Sulfate loss of loss	F	329			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			ON	COMPLETED		
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	EHAB		378 PROSPECT S	TREET		
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Retrieved January http://products.san Pharmaceutical Inf January 5, 2012, fr 483.25(m)(2) RES SIGNIFICANT ME The facility must e any significant me This REQUIREME by: Based on intervie failed to ensure th free of any signific #1). Findings including the investig 5, 2012, staff interrevealed that a se errors occurred, a review of staff not on 12/27/11 for er as alert, oriented, known. From 12/2 12/31/11, the residable to ask staff with a able to ask staff with a staff or ask staff with a	5, 2012, from ofi.us/ambien/ambien.pdf formation: Haldol. Retreived om http://www.rxmed.com. formation: Benadryl. Retreived om http://www.rxmed.com. formation: Ativan. Retrieved om http://rxmed.com. IDENTS FREE OF DERRORS Insure that residents are free of dication errors. ENT is not met as evidenced w and record review, the facility at one applicable resident was ant medication errors (Resident ude: Gation from January 4 - January views and record review ries of significant medication ffecting Resident #1. Per es, Resident #1 was admitted and of life care for Liver Cancer and able to make his/her needs 18/11 through the evening of dent was noted to be walker independently and was when s/he needed medications		F 333 Resident Care, exp from nati end stage documer Systems isolated i properly, in place, orders w time the The Amb available The facili of physic	pired on 1/1/12. Eural causes with de liver cancer/heponted on the death in place at the time incident were ope. Policies and Proceed Verification of the as made by 2 nurse orders were received order was curtin the medication of the medication of the medication of the medication orders, bringing ity did add one addian orders, bringing in the medication orders were received in the medication order were received in the medication orders were received in the medication or	Death was liagnosis of atitis C as certificate. The of this rating cedures were APRN ses at the lived. Trent and a cart. ditional check	k
			4 4,1100 0	peer review		
	ROVIDER OR SUPPLIER COURT HEALTH & R SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa Retrieved January http://products.san Pharmaceutical Inf January 5, 2012, fr Pharmaceutical Inf January 5, 2012, fr	ROVIDER OR SUPPLIER COURT HEALTH & REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 Retrieved January 5, 2012, from http://products.sanofi.us/ambien/ambien.pdf Pharmaceutical Information: Haldol. Retreived January 5, 2012, from http://www.rxmed.com. Pharmaceutical Information: Benadryl. Retreived January 5, 2012, from http://www.rxmed.com. Pharmaceutical Information: Ativan. Retrieved January 5, 2012, from http://rxmed.com. 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced	ROVIDER OR SUPPLIER COURT HEALTH & REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 Retrieved January 5, 2012, from http://products.sanofi.us/ambien/ambien.pdf Pharmaceutical Information: Haldol. Retreived January 5, 2012, from http://www.rxmed.com. Pharmaceutical Information: Benadryl. Retrieved January 5, 2012, from http://www.rxmed.com. Pharmaceutical Information: Ativan. Retrieved January 5, 2012, from http://rxmed.com. Pharmaceutical Information: Ativan. Retrieved January 5, 2012, from http://rxmed.com. Pharmaceutical Information: Ativan. Retrieved January 5, 2012, from http://rxmed.com. This reculting must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that one applicable resident was free of any significant medication errors (Resident #1). Findings include: During the investigation from January 4 - January 5, 2012, staff interviews and record review revealed that a series of significant medication errors occurred, affecting Resident #1. Per review of staff notes, Resident #1 was admitted on 12/27/11 for end of life care for Liver Cancer as alert, oriented, and able to make his/her needs known. From 12/28/11 through the evening of 12/31/11, the resident was noted to be ambulating with a walker independently and was able to ask staff when s/he needed medications	ROVIDER OR SUPPLIER ROUTH HEALTH & REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 Retrieved January 5, 2012, from http://products.sanofi.us/ambien/ambien.pdf Pharmaceutical Information: Haldol. Retreived January 5, 2012, from http://www.rxmed.com. Pharmaceutical Information: Benadryl. Retrieved January 5, 2012, from http://www.rxmed.com. Pharmaceutical Information: Ativan. Retrieved January 5, 2012, from http://rxmed.com. 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. 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ROVIDER OR SUPPLIER COURT HEALTH & REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 Retrieved January 5, 2012, from http://products.sanofi.us/ambien/ambien.pdf Pharmaceutical Information: Haldol. Retreived January 5, 2012, from http://www.rxmed.com. Pharmaceutical Information: Benadryl. Retrieved January 5, 2012, from http://www.rxmed.com. Pharmaceutical Information: Ativan. Retrieved January 5, 2012, from http://rxmed.com. Pharmaceutical Information: Ativan. Retrieved January 5, 2012, from http://rxmed.com. Pharmaceutical Information: Ativan. Retrieved January 5, 2012, from http://rxmed.com. The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that one applicable resident was free of any significant medication errors (Resident #1). Findings include: During the investigation from January 4 - January 5, 2012, staff interviews and record review revealed that a series of significant medication errors occurred, affecting Resident #1 was admitted on 12/27/11 for end of life care for Liver Cancer as alert, oriented, and able to make his/her needs known. From 12/28/11 through the evening of 12/31/11, the resident was noted to be ambulating with a walker independently and was able to ask staff when s/he needed medications	ROUNDER OR SUPPLIER COUNT HEALTH & REHAB SUMMARY STATEMENT OF DEFICIENCES (EACH DEPICIENCES (EACH DEPICIENCY MUST BE PRECEDED BY THAT REGULATORY OR LSC IDENTIFYING INFORMATION) CONTINUED From page 11 Retrieved January 5, 2012, from http://www.rxmed.com. Pharmaceutical Information: Aladol. Retreived January 5, 2012, from http://www.rxmed.com. Pharmaceutical Information: Aladol. Retrieved January 5, 2012, from http://www.rxmed.com. Pharmaceutical Information: Aladol. Retrieved January 5, 2012, from http://www.rxmed.com. Pharmaceutical Information: Aladol. Retrieved January 5, 2012, from http://www.rxmed.com. Pharmaceutical Information: Aladol. Retrieved January 5, 2012, from http://www.rxmed.com. Pharmaceutical Information: Benadryl. Retrieved January 5, 2012, from http://www.rxmed.com. Pharmaceutical Information: Benadryl. Retrieved January 5, 2012, from http://www.rxmed.com. Pharmaceutical Information: Benadryl. Retrieved January 5, 2012, from http://www.rxmed.com. Pharmaceutical Information: Benadryl. Retrieved January 5, 2012, from http://www.rxmed.com. Pharmaceutical Information: Benadryl. Retrieved January 5, 2012, from http://www.rxmed.com. Pharmaceutical Information: Benadryl. Retrieved January 5, 2012, from http://www.rxmed.com. Pharmaceutical Information: Benadryl. Retrieved January 5, 2012, from http://www.rxmed.com. Pharmaceutical Information: Benadryl. Retrieved January 5, 2012, from http://www.rxmed.com. Pharmaceutical Information: Benadryl. Retrieved January 5, 2012, from http://www.rxmed.com. Pharmaceutical Information: Benadryl. Retrieved January 5, 2012, from http://www.rxmed.com. Pharmaceutical Information: Benadryl. Retrieved January 5, 2012, from http://www.rxmed.com. Pharmaceutical Information: Benadryl. Retrieved January 5, 2012, from http://www.rxmed.com. Pharmaceutical Information: Advan. Retrieved January 5, 2012, from http://www.rxmed.com. F 333 F 333 F 333 F 335 Resident # 1 Admitted for End of Life Care, expired on 1/1/12. Death was from natural causes with

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) D PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SU COMPLE	(3) DATE SURVEY COMPLETED			
		475037	B. WIN			01/05	5/ 2012
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F 333	On December 31, recipient of a sign the resident received Ambien (a sedative insomnia) when the administer 2 mg of medication). The significant medical record not assessments duri regards to the poterror. Per record previous PRN (as for insomnia that but per staff intenthe medication card on 12/31/11, Per record review telephone orders	2011, Resident #1 was the ificant medication error where yed 20 milligrams (mg) of re/hypnotic medication used for the nurse was intending to if Ativan (an anti-anxiety re is no evidence of this ation error in the Resident's revidence of ongoing the following shifts in the ential effects of the medication review, Resident #1 had a needed) order for Ambien 5 mg was discontinued on 12/29/11, which with Nurse #1 on 1/4/12, rd was still in the medication available for staff to use.	F	333	Nurse #1 has an audit of a na pass weekly. Nurses #2 and monitoring plan in place to all orders are reviewed by DNS/designee. All residents receiving medithe potential to be affected alleged deficit practice. Nurses were re-educated or administration policy. Nurses were re-educated or and procedure for clinical documentation for medicat include not only the incident	#4 have a ensure that cations have by this namedication the policy ion errors to treport but	n !
	countersigned by mg Ativan every 4 cream 1 mg topic 4 mg Morphine si throughout the nic cream that contai (anti-anxiety), Bei (anti-psychotic) a nausea). Prior to dosages of the in follows for an 'as agitation, ordered 12.5 mg of Benacof Reglan. Per regions of the counterprise of the c	1/11 at 10:30 PM and were not the prescribing practitioner: 2 hours while awake, ABHR al every 2 hours scheduled, and abcutaneously every 2 hours ght. ABHR cream is a topical ns 4 medications: Ativan hadryl (anti-histamine), Haldol and Reglan (used for treatment of this telephone order, the cluded medications were as needed' dose to treat anxiety or lon 12/29/11: 0.5 mg of Ativan, dryl, 0.5 mg of Haldol, and 10 mg eview of drug information, side of the included medications as/sedation.			in addition, a notation in the record. Nurses were re-educated or for editing and transcribing orders. The nurses responsible for the medication errors were discreted on the medication administration process and errors policy.	n the policy of physician the ciplined and	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	COMPLE	
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F 333	Per interviews on 4:20 PM with the 1 on the telephone of stated that s/he di Nurse #1, but gav who was not in the verified that s/he of given every 4 hou verified that she dibe given every 2 his verified that the so given only through Prior to this teleph and the Morphine medications to treanxiety/agitation at Throughout the ni and through the diand ABHR cream nurses (Nurse #3 per the above me on 12/31/11. Per Resident #1 slept 1/1/12, and a note states the resider that the nurse concream and 4 mg ordered. The nur also states that the of apnea (tempor early at 9:30 AM, Morphine and ABM, Morphine and ABM,	1/4/12 at 1:40 PM and 1/5/12 at Nurse Practitioner (NP) noted order as giving the orders, s/he d not give the above orders to e different orders to Nurse #2 a facility at the time. The NP did not order Ativan 2 mg to be rs while awake. The NP also id not order the ABHR cream to hours scheduled, and also cheduled Morphine was to be nout the night shift. In one order, the ABHR cream were PRN (as needed) at complaints of and pain, respectively. ght shift of 12/31/11 - 1/1/12 ay shift on 1/1/12, the Morphine were given by 2 different and Nurse #4) every 2 hours intoned telephone orders written review of nurses' notes, all night from 12/31/11 to be for the day shift of 1/1/12 at slept throughout the shift, and intinued to administer the ABHR Morphine every 2 hours as sees' note by Nurse #3 on 1/1/12 are resident was having periods ary cessation of breathing) as yet staff continued to give the HR cream in the absence of	F	333	Daily review of new orders performed by DNS/designed check by nurses x 90 days. DNS/designee will perform weekly audits x 90 days of passes. DNS/designee will provide oversight to the nurses that involved in the medication days. Results of these audits will at monthly CQI meeting x 3. Date of compliance: Januar F333 POC accepted 212	ee for triple n random medication enhanced at were n errors for 90 be reviewed months. ry 25, 2012	ı
	per the above me on 12/31/11. Per Resident #1 slept 1/1/12, and a note states the resider that the nurse corcream and 4 mg ordered. The nur also states that the of apnea (tempor early at 9:30 AM, Morphine and AB signs or complair confirmed by the	ntioned telephone orders written review of nurses' notes, all night from 12/31/11 to e for the day shift of 1/1/12 at slept throughout the shift, and ntinued to administer the ABHR Morphine every 2 hours as ses' note by Nurse #3 on 1/1/12 he resident was having periods ary cessation of breathing) as yet staff continued to give the				13-11100016	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		E CONSTRUCTION	(X3) DATE S COMPL	
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	ROVIDER OR SUPPLIER COURT HEALTH & F	REHAB		378	T ADDRESS, CITY, STATE, ZIP CO PROSPECT STREET RRE, VT 05641	DE	
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F 333	was not exhibiting of pain or anxiety of the nurse stated the repeatedly given to symptoms. The 7 doses of AB Resident #1 without absence of signs of anxiety/agitation from 1/1/12 were signified doses of Morphine in the absence of signs of the significant medical present in the medical present in	signs of, nor made complaints during the day on 1/1/12, and that the Morphine was a treat the resident's respiratory. HR cream administered to ut a valid order and in the or complaints of om 2:00 AM to 2:00 PM on cant medication errors. The 3 given without a valid order and signs or complaints of pain from M on 1/1/12 were also tion errors. There was no order dical record to continue the ne administration into the 1/1/12. There is no evidence of ses (Nurse #3 or Nurse #4) scribing practitioner or or question the scheduled he Morphine or ABHR cream was asleep and/or having. The resident passed away in 1/1/12. drug manufacturer's prescribing the new the recommended dose ents with liver impairment is 5 ged elimination (the body taking ize and eliminate the drug). The varnings for Ambien include for impairment to use with caution the ly. Drug interactions for statement that it has enhanced effects with combination use.	F	333			
	Per review of drug	g information, Morphine causes					. \

	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER ROWAN COURT HEALTH & REHAB			•	37	EET ADDRESS, CITY, STATE, ZIP CODE 78 PROSPECT STREET ARRE, VT 05641			
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F 333	liver, and is indicate relief from severe princlude respiratory warnings include a use Morphine in a who are concurrent sedatives/hypnotics	sion, is metabolized by the ed to be used for symptomatic pain. Contra-indications listed depression. Manufacturer's warning to use caution and reduced dosage in patients	F	333				
	Morphine include a have a prolonged of in patients with liver of patients with liver of Morphine may last following a standar administration show interactions state that with other CNS depresses effects, stating that both agents is requisection states that are respiratory depression, respiratory depression, Cheyrold in patients of the control of the	a statement that Morphine may duration and cumulative effect or dysfunction, stating that in dysfunction, the effects of 6, 8 or even up to 24 hours of dose and that continuous all be avoided. Listed drug that Morphine in combination zers, sedative/hypnotics or sants has additive depressant to a dosage reduction of one or dired. The adverse reactions the major hazards of morphine pression, circulatory arrest, shock and cardiac of overdose include respiratory are-Stokes respiration, extreme in severe overdosage, apnea,						
	circulatory collapse occur. References: Pharmaceutical In Injection. Retreive http://www.rxmed. Highlights of Preserved January	formation: Morphine Sulfate and January 5, 2012, from com.						

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,	PLE CONSTRUCTION	(X3) DATE SUI COMPLET	
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F 333	Continued From p	page 16	F-333			
		nformation: Haldol. Retreived from http://www.rxmed.com.				
		nformation: Benadryl. Retreived from http://www.rxmed.com.				
F 514 SS=E	January 5, 2012, 483.75(I)(1) RES	nformation: Ativan. Retrieved from http://rxmed.com. PLETE/ACCURATE/ACCESSIB	F 514	F 514		
	resident in accord	maintain clinical records on each dance with accepted professional actices that are complete; nented; readily accessible; and ganized.		Resident # 1 Admitted Care, expired on 1/1/1 from natural causes wi end stage liver cancer/	2. Death was th diagnosis of hepatitis C as	
	information to ide resident's assess services provided	d must contain sufficient entify the resident; a record of the ments, the plan of care and the results of any eening conducted by the State; es.		Systems in place at the isolated incident were properly. Policies and in place.	e time of this e operating	e
	by: Based on intervifailed to assure emaintained in accurately docurresident (Reside	ew and record review, the facility each resident's clinical record is cordance with accepted idards that are complete and nented for one applicable int #1). Findings include: w and interview, Nurse #1 curate telephone/verbal orders in		Resident's increasingly behaviors, increased a complaints of pain 12, required physician nowere obtained at that APRN (covering for the physician) read back for nurse#1 and witnesse	anxiety, and /28/11-12/31/11 tification. Order time from the e attending for verification by	S

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NAME OF PROVIDER OR SUPPLIER ROWAN COURT HEALTH & REHAB STREET ADDRESS, CITY, STATE, ZIP CODE 378 PROSPECT STREET BARRE, YO 05641	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
INAME OF PROVIDER OR SUPPLIER ROWAN COURT HEALTH & REHAB SIRRET ADDRESS. CITY, STATE, ZIP CODE 378 PROSPECT STREET BARRE, VT 05641 SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPOCIENCY MIST are PROCEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 514 Continued From page 17 the record of Resident #1, and 2 nurses (Nurse #3 and Nurse #4) implemented the inaccurate orders for Resident #1 from 2:00 AM on 12/31/11 to 2:00 PM on 11/1/12. In addition, there was no documentation of a significant medication error that occurred on 12/31/11 in the medical record. Per review of staff notes, Resident #1 was admitted on 12/27/11 for end of life care due to Liver Cancer as alert, oriented, and able to make his/her needs known. From 12/28/11 through the evening of 12/31/11, the resident was noted to be ambulating with a walker independently and was able to ask staff when she needed medications to treat symptoms. On December 31, 2011, per staff interview, Resident #1 was the recipient of a significant medication error where the resident received 20 milligrams (mg) of Ambien (a seadtive/hypnotic medication or evidence of ongoing assessments during the following shifts in regards to the potential effects of the medication error. Per record review on 1/4/12, the following inaccurate telephone orders were transcribed and signed by Nurse #1 on 12/31/11 at 10:30 PM and were not countersigned by the prescribing practitioner: 2 mg altivan every 4 hours while awake and ABHR cream 1 mg topical every 2 hours scheduled. ABHR cream is a topical cream			475037			
F 514 Continued From page 17 the record of Resident #1, and 2 nurses (Nurse #3 and Nurse #4) implemented the inaccurate orders for Resident #1 from 2:00 AM on 12/31/11 to 2:00 PM on 1/1/12. In addition, there was no documentation of a significant medication error that occurred on 12/31/11 in the medical record. Per review of staff notes, Resident #1 was noted to be ambulating with a walker independently and was able to ask staff when s/he needed medications to treat symptoms. On December 31, 2011, per staff interview, Resident #1 was the recipient of a significant medication error where the resident received 20 milligrams (mg) of Ambien (a sedative/hypnotic medication error where the resident received 20 milligrams (mg) of Ambien (a sedative/hypnotic medication error where the resident received 20 milligrams (mg) of Ambien (a sedative/hypnotic medication error where the resident received 20 milligrams (mg) of Ambien (a sedative/hypnotic medication error where the resident received 20 milligrams (mg) of Ambien (a sedative/hypnotic medication error where the resident received 20 milligrams (mg) of Ambien (a sedative/hypnotic medication error where the resident received 20 milligrams (mg) of Ambien (a sedative/hypnotic medication error where the resident received 20 milligrams (mg) of Ambien (a sedative/hypnotic medication error where the resident received 20 milligrams (mg) of Ambien (a sedative/hypnotic medication error where the resident received 20 milligrams (mg) of Ambien (a sedative/hypnotic medication error where the resident received 20 milligrams (mg) of Ambien (a sedative/hypnotic medication error where the resident received 20 milligrams (mg) of Ambien (a sedative/hypnotic medication error where the resident received 20 milligrams (mg) of Ambien (a sedative/hypnotic medication error where the recipient of a significant medication error where					378 PROSPECT STREET	
the record of Resident #1, and 2 nurses (Nurse #3 and Nurse #4) implemented the inaccurate orders for Resident #1 from 2:00 AM on 12/31/11 to 2:00 PM on 1/1/12. In addition, there was no documentation of a significant medication error that occurred on 12/31/11 in the medical record. Per review of staff notes, Resident #1 was admitted on 12/27/11 for end of life care due to Liver Cancer as alert, oriented, and able to make his/her needs known. From 12/28/11 through the evening of 12/31/11, the resident was noted to be ambulating with a walker independently and was able to ask staff when s/he needed medications to treat symptoms. On December 31, 2011, per staff interview, Resident #1 was the recipient of a significant medication error where the resident received 20 milligrams (mg) of Ambien (a sedative/hypnotic medication used for insomnia) when the nurse was intending to administer 2 mg of Ativan (an anti-anxiety medication). There is no evidence of this significant medication error in the Resident's medical record nor evidence of ongoing assessments during the following shifts in regards to the potential effects of the medication error. Per record review on 1/4/12, the following inaccurate telephone orders were transcribed and signed by Nurse #1 on 12/31/11 at 10:30 PM and were not countersigned by the prescribing practitioner: 2 mg Ativan every 4 hours while awake and ABHR cream is a topical every 2 hours scheduled. ABHR cream is a topical cream	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	X (EACH CORRECTIVE / CROSS-REFERENCED T	ACTION SHOULD BE COMPLETION DATE
Benadryl (anti-histamine), Haldol (anti-psychotic) F514 POC a ccepted 212112 PMCotaRN and Reglan (used for treatment of nausea)	F 514	the record of Reside #3 and Nurse #4) in orders for Resident to 2:00 PM on 1/1/documentation of a that occurred on 12 Per review of staff admitted on 12/27/ Liver Cancer as alchis/her needs know evening of 12/31/1 ambulating with a vable to ask staff who to treat symptoms. On December 31, Resident #1 was the medication error would milligrams (mg) of medication used for was intending to account anxiety medical record nor assessments during regards to the potential record review of inaccurate telephosigned by Nurse #1 were not counters practitioner: 2 mg awake and ABHR hours scheduled. A that contains 4 me Benadryl (anti-histal)	lent #1, and 2 nurses (Nurse implemented the inaccurate it #1 from 2:00 AM on 12/31/11 in 2. In addition, there was no a significant medication error 2/31/11 in the medical record. In the implemented, and able to make with the resident was noted to be walker independently and was nen s/he needed medications. 2011, per staff interview, he recipient of a significant here the resident received 20 Ambien (a sedative/hypnotic per insomnia) when the nurse administer 2 mg of Ativan (an action). There is no evidence of dication error in the Resident's revidence of ongoing ag the following shifts in ential effects of the medication. On 1/4/12, the following ne orders were transcribed and 1 on 12/31/11 at 10:30 PM and gned by the prescribing. Ativan every 4 hours while cream 1 mg topical every 2 ABHR cream is a topical cream dications: Ativan (anti-anxiety), amine), Haldol (anti-psychotic)	F 5	Nurses were re-eand procedure for documentation from include not only in addition, a not record. The nurs medication error re-educated on tradministration procedure formed by Discheck by nurses DNS/designee wreekly audits x spasses. DNS/designee wreekly audits x spasses.	educated on the policy or clinical for medication errors to the incident report but tation in the medical es responsible for the rs were disciplined and the medication process and medication process and medication will be NS/designee for triple x 90 days. Will perform random 90 days of medication will provide enhanced nurses that were medication errors for 90 audits will be reviewed meeting x 3 months. Ince: January 25, 2012

FORM CMS-2567(02-99) Previous Versions Obsolete

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CONST LDING	TRUCTION	COMPLE	COMPLETED	
		475037	B. WIN	IG		i	C 5/2012	
	ROVIDER OR SUPPLIER	EHAB			RESS, CITY, STATE, ZIP CO PECT STREET /T 05641	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EA	PROVIDER'S PLAN OF CO ACH CORRECTIVE ACTIO SS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 514	Per interviews on 14:20 PM with the Non the telephone of stated that s/he did Nurse #1, but gave who was not in the verified that s/he digiven every 4 hours ordered a one time increased anxiety the prior to the significal Ambien. The Ativa #1. The NP also with the ABHR cream to scheduled, indicating to be used per a plan as needed basing anxiety or agitation. Throughout the night he day shift on 1/2 given by 2 differen #4) every 2 hours mentioned telephor Per review of nurs night from 12/31/1 Nurse #3 for the diresident slept throughout the night from 12/31/1 Nurse #3 for the diresident slept throughout the night from 12/31/1 Nurse #3 for the diresident slept throughout the night from 12/31/1 Nurse #3 for the diresident slept throughout the night from 12/31/1 Nurse #3 for the direction from 12/3	Al/4/12 at 1:40 PM and 1/5/12 at Jurse Practitioner (NP) noted refer as giving the orders, s/he I not give the above orders to a different orders to Nurse #2 facility at the time. The NP id not order Ativan 2 mg to be s while awake, but rather a dose of Ativan to be given for that was reported to the NP ant medication error involving an was not given to Resident rerified that she did not order to be given every 2 hours and that the ABHR cream was revious order on 12/29/11 on s for signs or complaints of the notes (Nurse #3 and Nurse scheduled per the above one orders written on 12/31/11. es' notes, Resident #1 slept all 1 to 1/1/12, and a note by any shift of 1/1/12 states the ughout the shift, and that the order administer the ABHR cream lent #1 passed away around	F	514				
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